WIC PEDIATRIC REFERRAL

benefits since Program eligibility requirements must be met. Patient's name (last, first) Parent/guardian name		PLEASE NOTE: WIC provides iron-fortified co		Birth da		Sex	
						☐ Male	Female
		Address (street, city, ZIP code)		<u> </u>			Phone number
CURRENT	CURR (For patients 9 m		BIRTH DATA (For patients under 12 m	onths)	BLOOI	D LEAD TE	ST
Length/height ins.	Hemoglobin	gm/dl	Birthweight	_ lbs.		Date	μg/dL
Weight lbs.	and/or Hematocrit	%	Birthlength	_ ins.	12-month result		
Macourement Date			Small for gestational age		24-month result		
Measurement Date IF FORMULA WILL BE NECESSARY AFT	Blood Test ER AGE 1 YEAR, REASO		Preterm (less than 37 wks) RMULA MUST BE INDICATED:				
Reason:							
Type: Estimated time needed:							
PLEASE INDICATE ANY MEDICAL CONI	ITIONS AFFECTING TH	IS PATIENT:					
☐ Food Allergies ☐ Congenital An	omalies	opmental Disabilities	Severe Dental Probler	ns 🗖	Illness, Acute	Illness, Cl	hronic
Other (specify):							
PLEASE DESCRIBE ANY OF THE COND	ITIONS INDICATED ABO	OVE. INCLUDE DATE	S WHEN APPLICABLE:				
PLEASE LIST ANY CURRENT MEDICAT	ONS/SUPPLEMENTS PE	RESCRIBED:					
LOCAL WIC AGENCY:		Na	ame of Physician/Health Care P	rovider/Group	o/Clinic		
		-	none Number:	Lev Health	Oses Brouidor		
		IIV	IPORTANT: Must Be Signed	Г Бу Пеанн	Care Provider		
PM 247 A (1/01)	The USE		rtunity provider and employe				
Health Care Provider:			VIA DECEDEAL		VVIC	: Supplemental	f Health Services Nutrition Branch
Please provide the information and to provide nutritional counseling	equested below for yo An incomplete referra	our patient. This info Il may delay Prograr	n benefits to your patient. A	completed	taff to assess you referral does not	ır patient's I guarantee V	Nutrition Branch health status VIC Program
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